CALIFORNIA DEPARTMENT OF INSURANCE
FRAUD DIVISION

Fiscal Year 2002-2003
Report on the Program to Investigate & Prosecute
Workers' Compensation Insurance Fraud

In California, workers' compensation insurance is a no-fault system. Injured employees need not prove the injury was someone else's fault in order to receive workers' compensation benefits for an on-the-job injury. The National Insurance Crime Bureau estimated in the year of 2000 that workers' compensation insurance fraud is the fastest-growing insurance scam in the nation, costing the industry billions each year. The thievery happens in medical clinics, law offices and even your neighbor's home. Insurance companies pick up the tab, passing the cost on to policyholders, taxpayers and the general public.

California's workers' compensation law was passed by the state Legislature in 1913. The compromise between labor and management was designed to shield employers from liability regardless of fault, and to provide workers with appropriate benefits for all workplace injuries. In 1995, according to the Workers' Compensation Insurance Rating Bureau, the total cost of workers' compensation in California to private employers, public entities, and self-insured businesses was $9 billion. Today, eight years later, and serving fewer injured workers, California's Workers' Compensation system costs $28 billion. This is in effect a $19 billion tax increase on businesses.

In California, workers' compensation is required for all statutory employees. It is the responsibility of the California Department of Insurance (CDI) to oversee the financial health of licensed workers' compensation insurers. It is the responsibility of the Department of Industrial Relations (DIR) to ensure that funds are available to pay the claims of all self-insured work injuries.

The increase in insurance fraud particularly during the early 1990's led many to regard insurance fraud as the crime of the 90s. Workers' Compensation insurance fraud came to a forefront as a focused insurance fraud problem in the late 1980's when people who lined up in the unemployment line in the Employment Development Department were recruited by cappers to file for workers' compensation stress claims.

Several reasons for new growth in this criminal industry were:

- A vulnerability of the workers' compensation system to inflate claims by medical and/or legal mills,
- Public acceptance about insurance fraud,
- Personal economic hardship, due to loss of work.
- Increasing opportunities for fraud, and

- Lack of adequate resources, such as manpower and funding, to investigate insurance fraud cases.

The program in California to combat workers' compensation fraud was established in 1991 through the passage of SB 1218 (Chapter 116). The law made workers' compensation fraud a felony, required insurers to report suspected fraud, and established a mechanism for funding enforcement and prosecution activities. SB 1218 also established the Fraud Assessment Commission to determine the level of assessments to fund investigation and prosecution of workers' compensation insurance fraud. The funding comes from California employers who are legally required to be insured or self-insured. The Fraud Division receives mandated funding through the Fraud Assessment Commission. The Commission membership, appointed by the Governor, is comprised of five individuals representing self-insurers, insured employers, workers' compensation insurers, and the President of the State Compensation Insurance Fund, who serves as an ex-officio member. In September 2003, two additional assessment members were added to the commission as mandated by the passage of AB 749. These members are representatives from organized labor.

Workers' compensation claims fraud raises the frequency of claims, average claim costs and the workers' compensation system costs. This, in turn, causes higher insurance rates, employer-paid premiums and, ultimately, a loss of jobs. Data reported by district attorneys in fiscal year 2002-03 indicated that prosecution of 660 fraud cases with 739 suspects represented $54,657,482 of chargeable fraud. This $55 million represents only a small portion that has been charged and not necessarily all that is identified as fraud since many fraudulent activities have not been identified or investigated.

Effective January 1, 2003, the Fraud Division and county district attorneys have been allowed to use the assessment funding to investigate and prosecute the crime of "willful failure" by employers to secure payment of workers' compensation, a violation of the Labor Code, as a misdemeanor offense. The fraud scheme primarily focuses on employers who intentionally underreport their payroll, misclassify their employees' work descriptions, evade experience modifications by lying about their business ownership, or intentionally denying workers' compensation benefits. In order to identify employer misrepresentation violators, the Fraud Division has been included in the Underground Economy Task Force.

Historically, prosecutors and the California Department of Insurance, Fraud Division focused on detecting fraud claims generally committed by workers and legal and medical service providers. It is the intention of the Department that the foremost targets of fraud program resources should be medical provider fraud and employer premium fraud. In the past few years, the Fraud Division's focus has shifted to premium fraud committed by employers who file false payroll information to reduce insurance premiums. Furthermore, the Fraud Division also targets medical mills that have become highly organized sophisticated providers by up-coding their fees.

The first line of defense is the insurer or self-insured employer (the entities actually involved in processing claims). The Fraud Division's mission statement includes an Outreach Program to private and public sectors. Fraud Regional Office staff has met with and trained

numerous self-insured organizations on how to more accurately report Suspected Fraudulent Claims (SFCs).

Effective July 1992, all insurers in California were required to establish and maintain Special Investigative Units (SIU) and a system for detecting and reporting fraud. Prior to inception of this program, the average annual number of SFCs reported to the Fraud Division was approximately 50 statewide. From July 1992 through June 2003, the Fraud Division has reviewed 47,974 workers' compensation SFCs.

Reporting Suspected Fraudulent Claims (SFCs)

SFCs are reports of suspected fraudulent activities that are originated by insurance carriers, informants, witnesses, law enforcement agencies and fraud investigators.

Fiscal Year	SFCs Reported
1992-93	8,342
1993-94	7,284
1994-95	4,004
1995-96	3,947
1996-97	3,281
1997-98	4,331
1998-99	3,363
1999-00	3,362
2000-01	3,548
2001-02	2,968
2002-03	3,544

The number of SFCs has fluctuated around 3,500 SFCs each year. Several reasons for this trend include:

- lower claims frequency,
- removal of major medical and legal mills involved in illegal activities,
- reduction in insurers' SIUs,
- deterrence effects resulting from statewide anti-fraud efforts of local district attorneys, the Fraud Division and the insurance industry, and
- fewer insurance companies in the California workers' compensation market.

The opportunity to commit fraud is a factor of the number of employees, employers and workers' compensation doctors and lawyers who can commit fraud. Consequently, the occurrence of fraud is also proportionate to these numbers.

Workers' Compensation Fraud Schemes

After ten diligent years of comprehensive anti-fraud efforts, the Fraud Division and district attorneys identified many types of workers' compensation fraud.

Applicant Fraud
Applicant fraud occurs when a claimant files a false claim for an injury supposedly sustained in the workplace. Applicant fraud can vary from simple misrepresentations to more elaborate, multiple overlapping claims.

Applicant Fraud Schemes
Denying prior workers' compensation claims
Denying prior injuries to the same body part
Denying working while collecting disability benefits
Denying the ability to do various activities or functions
Being injured away from work and reporting it as a Workers' Compensation claim

Insider Fraud - Embezzlement
The crime of insider fraud necessitates access to the financial processes of an insurance company's claims adjusting unit. An employee with access can write a check or authorize payment to someone outside the insurance company. The outsider then cashes the check and takes his share. In another example, the claims agent may fail to report a paid insurance premium and simply pocket the premium. The agent may also delay payment of a claim by temporarily placing the money in an interest-bearing account in his name. Deterrence in this area comes from the effective prosecution of insiders, sending the message that insurers are monitoring their internal controls.

Treatment Fraud
Based on interviews and review of suspected fraudulent behavior, attorneys and service providers who were previously involved in the operation of medical-legal mills have now diversified and specialized in treatment fraud. While claims are low, reports indicate that treatment claim frequency is up, and the costs of medical treatment continue to rise. Treatment fraud, which is based on legitimate injuries, occurs in the offices of medical practitioners or in medical-legal mills. Detecting and prosecuting medical providers who have no intention of helping their patients is a very costly and serious crime that often requires many hours of undercover investigation to determine and prove.

Treatment Fraud Schemes
Up-coding
The treatment bill represents a procedure code for a more complicated procedure than actually performed.

Unbundling
The treatment bill reflects a breakdown of individual procedure codes that properly belong grouped in one code at a lower price.

Prescription Drugs Billing for expensive, brand name drugs when generic drugs were dispensed. Billing for a quantity or strength greater than actually dispensed. Unnecessary x-rays, exams and treatment prolong the length of the claim and attempt to make the injury appear to be more serious than it is.

Durable Medical Equipment Continued rental and subsequent purchase, or billed as a new purchase, when used equipment or no equipment is actually prescribed.

Services Never Rendered Patients sign-in for more visits than actually occurred and/or padding the bill with treatment modalities that are not actually provided.

Although public opinion does not perceive workers' compensation defrauders as dangerous criminals, the awareness of treatment fraud might change the general public's view. Unlike medical-legal fraud where most of the patient's claims are entirely fraudulent, the victim of treatment fraud is a true patient who is in need of real medical care.

Medical-Legal Mills

Although many of the most flagrant mills operating in California have been investigated and prosecuted, medical-legal mills are still operating. The nature of the workers' compensation system and the minimal accountability demanded of service providers documenting medical-legal fraud and determining criminal responsibility are exceptionally difficult to detect.

The medical-legal mill repetitively defrauds insurers and policyholders by causing the filing of fraudulent claims. Corrupt medical or legal professionals usually initiate these mills. The mills constitute a segment of insurance fraud that is labeled "white collar crime" by the industry. The scheme involves the corrupt attorney employing people known as "cappers" to recruit both legitimate and fraudulent accident victims who are the backbone of the mill operation. The cappers are generally paid a flat fee, up to several thousands per client, depending on the referral. A capper might be a clinic employee, a legal administrator, an emergency room attendant, or an emergency medical technician – someone that has contact with injured or potentially injured people.

Media-generated Fraud Schemes

In media-generated fraud, the applicant usually has less sophisticated motives. Laid-off or simply disgruntled with work, the applicant becomes aware of the possibility of entitlement to relief or compensation through media advertisements promising fast cash. These advertisements target claimants in mass quantities and showcase hotline numbers for referral services to funnel new patients/clients into medical or legal mills. The claimants who decide to participate in the media-driven schemes are usually coerced into making false or exaggerated claims to realize promises of fast cash. To address the media-generated applicant fraud, statutory prohibitions have recently been placed on these hotline and referral advertisements.

Organized Crime

Organized rings generally involve the figure head or office managers who run the bogus office for an absentee attorney. The attorney is hired to "lend a license" to the operation for the appearance of legitimacy. The attorney may be paid a percentage of the gross profits or a straight monthly salary for simply allowing a name and license to be used by the ring operators. The attorney has no control over the cases or the financial account of the law office. Since most workers' compensation cases are settled without going to trial, the

attorney's presence is never actually needed. These organized rings have grown over the past several years.

Employment Misrepresentation

While the private sector is primarily responsible for California's economic growth, state government has helped create the environment that allows businesses to flourish equally. Although most businesses have complied with regulations, there are businesses that do not have all their employees on the official company payroll. Additionally, not all of the wages paid to employees are recorded to reflect their real job duties. These businesses are unfairly competing with employers who are complying with the law. Often, honest businesses will go out of business or begin participating in the underground economy and commit workers' compensation employment misrepresentations.

A study by the federal Labor Department indicated that nearly one-third of garment companies investigated appeared to be operating in the underground economy by paying their employees in cash without the appropriate deduction statement. More than half of the employers violated the minimum wage and overtime provisions which also violates workers' compensation insurance premium laws. These companies cripple the efforts of honest companies to make a profit. Under state law, employers not carrying valid workers' compensation coverage are considered uninsured and face a Stop Notice and Penalty Assessment from the Labor Commissioner. A recent amended Labor Code 3700.5 allows that uninsured employers who fail to secure workers' compensation can be fined up to $10,000 and/or imprisonment in the county jail for up to one year. If an injury occurs, the fine increases to $10,000 per employee. A worker injured while working for an uninsured employer can sue for damages and the employer is presumed negligent in such cases. The cost of injuries to employees of uninsured employers is borne by the Uninsured Employers Fund (UEF); a program managed by the Department of Industrial Relations (DIR) and mostly funded by general fund tax revenues. The UEF pays costs such as medical treatment, disability benefits, and vocational rehabilitation. In such cases, DIR files liens against the employer's property in attempts to recover costs and reimburse taxpayers. However, costs to taxpayers because of uninsured employers has grown steadily each year and cost taxpayers more than $100 million in the past 5 years.

In 1994, the governor ordered establishment of the Underground Economy Joint Enforcement Strike Force consisting of the Employment Development Department (EDD), the Labor Commissioner's Office, Department of Consumer Affairs, and the Franchise Tax Board. With the passage of AB 202, effective January 2002, the Department of Insurance was named as the newest member of the Strike Force.

Based on 2001 information from EDD, the California underground economy is estimated at $60 billion to $140 billion. The estimated size of the underground economy is anywhere from 3 to 40 percent of the above ground economy. Businesses operating in the underground economy avoid payment of payroll and sales taxes by not reporting activities or by paying for goods and services in cash. Such businesses frequently are unlicensed and violate labor laws which require payment of minimum wage and withholding of taxes

instead of paying in cash without proper records and not having workers' compensation insurance.

Through the passage of SB 1053 by Senator Solis (Chapter 885, Session 1995-96), employment misrepresentation was incorporated into the mission of the Fraud Division effective January 1996. Employment misrepresentation has a direct impact on the economic health of the state. Unfairly assessed premiums each year cost employers millions of dollars. Employers, who misrepresent the facts about their business or their employees in order to reduce their workers' compensation cost, sully the business climate especially for small employers. Employment misrepresentation hits certain business sectors hard such as the construction and the garment industries where the margin of profit is already small. In June 2001, a joint study by the Department of Industrial Relations and EDD indicated that approximately 25% of employers have no workers' compensation insurance. With more than 1 million employers in California, at least 250,000 employers may not carry workers' compensation insurance. Under current laws, insured employers are subject to felony premium fraud charges for violations, while those who are not insured are only subject to misdemeanors.

Workers' compensation employment misrepresentation is defined as "any person who willfully misrepresents any fact in order to obtain workers' compensation insurance at less than the proper rate for that insurance". Employers violate the law by:

- underreporting the amount of their payroll,
- intentionally misclassifying the jobs of their employees, or
- evading experience modifications by lying about their business ownership.

Employment Misrepresentation Schemes

Underreporting Wages

For example, a former employee of "Construction" approached the California Department of Insurance with information that the owner of the business was in violation of workers' compensation employment law. The employee supplied the Fraud Division with copies of "Construction's" certified public works payroll records with misclassified employees and duplicate employee time cards. The owner of "Construction" instructed the payroll clerk to classify carpenters as "Salespersons Outside" on the insurance company's monthly payroll reports in order to obtain premium at lower costs. A search warrant was executed. Relevant evidence seized included duplicate time cards, payroll records, copies of signed certified payroll, construction contracts, cancelled checks, bank statements, and various other business records. The evidence revealed "Construction" records did not match hours worked, job sites and duties performed when compared to corresponding weekly certified payroll of public work projects signed under penalty of perjury by the owner.

Reclassify Employees' Work Description
A building permit (valued at $70,000) issued in April 1994 to "Roofing" by the City Building Inspection Division, listed the work description as re-roofing of a commercial building. A contract (valued at $35,777) dated May 1994 through July 1994 awarded to "Roofing" described the contract work as re-roofing at various sites. Monthly payroll reports submitted to the insurance company for April through July 1994 did not report any payroll for employees categorized as "roofers", instead the "Roofing" listed payroll of employees categorized as "painters".

Underreporting Payroll
The owners of "Roofing Company" were charged with felony counts of workers' compensation employment misrepresentation and grand theft after an investigation by the CDI. "Roofing Company" submitted false documents to the State Compensation Insurance Fund thereby avoiding paying the proper premium for the firm's workers' compensation policy. A preliminary audit found that the company, which employed more than 100 people, underreported its payroll costing its insurer more than $1 million in lost premium.

Based on the mission statement of the Fraud Division, employers who falsify their records to underpay their premiums, (Insurance Code Sections 11760 and 11880) should be prosecuted to the full extent of the law.

Fraud Division

From July 1992 through June 2003, the Fraud Division opened 6,544 new cases. A complex case may involve several thousand hours or many months of investigative time, particularly if the case involves an undercover operation or has multiple defendants. Cases investigated by the Fraud Division vary from one defendant and small dollar loss to multiple defendants and estimated millions of dollars in loss. The Fraud Division ranks cases based on dollar value, number of defendants, and doctor and attorney involvement.

Insurance fraud cases can range from:

Priority 4	10 or more suspects, one or more attorneys or doctors, multiple criminal acts, and a loss value over $100,000.
Priority 3	1 or more suspects and/or doctor/lawyer involvement with a loss less than $100,000;
Priority 2	1 suspect and loss between $400 to $25,000;
Priority 1	1 defendant and a loss value under $400;

During fiscal year 2002-03, the Fraud Division, Office of Management, Analysis and Reporting (OMAR) reported that the Fraud Division investigated 1,606 workers' compensation fraud cases. (Many of these cases were closed at the end of the fiscal year). Effective July 1, 2003, 934 cases were being investigated as follows:

Priority 4	157 cases
Priority 3	184 cases
Priority 2	590 cases
Priority 1	3 cases
Total	**934 cases**

The breakdown by case priority category was developed in 1992 and provides an important tool for demonstrating the actual level of effort and resources required to pursue some of the more egregious fraud operators. The Fraud Division maintains a balanced caseload in order to assure that all types of insurance fraud will be investigated and prosecuted.

The Fraud Division uses a team strategy. Each team of peace officers can be comprised of eight to ten Fraud Investigators, a Supervising Fraud Investigator I and support staff. Team members are trained in workers' compensation, automobile and all lines of insurance fraud. In 1992, the Fraud Division had three offices in California: San Francisco, Los Angeles, and Sacramento. Since FY 1995-96, the Fraud Division added six regional offices in Orange, Rancho Cucamonga, Fresno, San Diego, Morgan Hill, and Valencia.

Suspected Fraudulent Claims Referral Process

Suspected Fraudulent Claims (SFCs) are reports of suspected fraudulent activity. Insurance carriers, informants, witnesses, law enforcement agencies, and fraud investigators originate reports. SFCs handling is divided into three main process categories: (1) intake; (2) evaluation and analysis; and (3) the assignment/rejection of cases.

Since the beginning of FY 1997-98, the SFCs received at the Fraud Division headquarters and are sent to the field offices for processing. After receiving a SFC, each Regional Office reviews the claim and makes contact with the insurer to advise that the case is being opened for investigation, needs more information, or there is not enough evidence currently to pursue. All SFCs are cataloged into a database for intelligence and information for analysis. When the Fraud Division receives more evidence, or as soon as investigative resources become available, the SFC becomes an open case investigation.

Special Investigative Unit (SIU) Compliance Review Office

In July 1992, Senate Bill 953 amended the Frauds Prevention Act (FPA) requiring insurers to establish and maintain special investigation units (SIUs). Insurers' SIUs are responsible for investigating possible instances of insurance fraud perpetrated against their company.

On June 2, 1994, the California Code of Regulations (CCR) adopted Section 2698.40 et seq. Title 10, Chapter 5, Subchapter 9, article 2, which addressed the insurers' SIUs. Those issues are Purpose and Objectives, Definitions, Functions and Activities, Elements for a Systematic Anti-fraud Strategy' Oversight and Maintenance of the Unit, and Penalties for Non-Compliance.

The primary responsibilities of the SIU Compliance Office are to inspect insurance companies to ensure regulatory compliance regarding the establishment, maintenance and

operation of the SIU, and to receive and review the insurer's initial and annual SIU compliance report of SIU operations.

The majority of California licensed insurers are required to establish and maintain SIUs according to California Insurance Code §1875.20 et seq. and California Code of Regulations §2698.40 et seq., title 10, Chapter 5, Subchapter 9, article 2. These regulations require insurers to have adequately staffed and trained SIUs that identify and investigate incidents of suspected insurance fraud and refer those cases to the Fraud Division for criminal investigation and prosecution. Additionally, the SIUs must provide procedures and training to the insurer's integral anti-fraud personnel who enables them to detect and identify incidents of suspected insurance fraud and refer those cases to the SIU for investigation and potential referral for criminal investigation.

During fiscal year, 2002-03, the SIU Compliance Office conducted 52 reviews that included 27 insurance companies that transact workers' compensation insurance. The operations of these companies were examined for compliance with the applicable regulations regarding the establishment and maintenance of an SIU. The majority of the companies reviewed were found to have viable SIUs.

Training and Education

The Department of Insurance, Fraud Division continues to expand and enhance its training program. Since fiscal year 1997/98, Fraud Division investigative staff (including supervisors and investigator assistants) has attended a four-week Basic Investigator Course (BIC), developed and implemented by the Fraud Division Training Committee. The BIC targets the elements of an effective investigation, surveillance, use of informants, interview and interrogation, legal update and the investigation of staged accidents and auto-related fraud. Additionally, investigative staff members from several California District Attorneys' Offices and local law enforcement agencies have attended portions of this course. The BIC outline has been requested by, and distributed to, insurance fraud units in the states of Florida, Idaho, New York, Kentucky, New Hampshire, Georgia, Kansas, Nebraska, Tennessee, Louisiana, Arkansas, Nevada, Alabama, Montana, Alaska, North Carolina, Delaware, and New Mexico.

The BIC outline continues to reflect the strong emphasis by the Fraud Division on its training program during Fiscal Year 2002-2003. The Fraud Investigator Development Program (initiated by the Fraud Division in 1997-1998) continues to introduce new investigators to the realities and responsibilities of criminal insurance fraud investigations. The program is guided by a job-related, standardized training curriculum, and it includes an Orientation to the Branch, a four-week Basic Investigator Course, and 135 days of individualized phase training. During the phase training, which is conducted at the Regional Offices, the trainee is assigned to a Training Investigator who monitors, trains and documents the new investigator's progress.

Due to the State hiring freeze, the Fraud Division was not able to hire significant numbers of new Fraud Investigators. As a result, only one class (comprised of 6 new investigators)

completed the training course. At the conclusion of the training the investigator can meet that part of the Fraud Division's mission of protecting the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud. In Fiscal Year 2002-2003, Fraud Division provided training in workers' compensation and staged auto accident insurance fraud to approximately 40 individuals from county district attorney's offices and local law enforcement agencies.

Despite the hiring freeze and state budget crises, the Fraud Division has continued to enhance its training programs. In addition to the Basic Investigator Course, the Fraud Division developed and presented a four-day Supervisory Leadership Development course to newly promoted supervisors. This course was designed to introduce newly promoted supervisors to foundational information on the role of a supervisor and thereby ensure that Fraud Division supervisors are fully trained and informed.

Additionally, first level supervisors with the Branch receive training in case management, grant funding, budgets, technology services, fleet administration, labor relations, outreach, media relations, career development, and supervisory skills. Ongoing training continues in the areas of officer safety (firearms, arrest and control, building entry and surveillance), computer technology and forensics, interview and interrogation, and organized crime. Training for Fraud Division investigators also included attendance at major law enforcement conferences sponsored by the California District Attorney's Association and the Southern and Northern California Fraud Investigator Associations.

The Fraud Division provides additional training to Fraud Investigators to ensure that all peace officer staff adheres to the requirements set forth by the Commission on Peace Officer Standards and Training (POST). This training also ensures that Fraud Investigators qualify for Basic, Intermediate, Advanced, Supervisory, and Management POST certificates. Moreover, Fraud Division support staff benefit from ongoing training on law enforcement topics, time management, computer software utilization, database management and business skills.

The Fraud Division continues to work with the California Workers' Compensation Institute and the Workers' Compensation Fraud Advisory to provide training for the industry. The Fraud Division facilitates the opportunity for the SIUs to receive training in all areas of workers' compensation insurance fraud.

Fraud Integrated Database System

The Fraud Integrated Database System (FIDB) has replaced the Insurance Fraud Information System, CaseTrac and Fraud Investigator Case Management System, with one statewide system which integrates data from all Regional Offices and Information resources. With FIDB system, the Fraud Division now has one single database to house case and investigative information to ensure that an effective and efficient communication mechanism to relay and house sensitive case information.

The FIDB system establishes and Intranet site that allows Fraud Division's staff:

- On-line access, via Intranet, permitting input and/or retrieval of data such as case activity notes, time, case contacts, investigative plans and allows database search.
- Liking and viewing of cases involving the same suspects(s) on a statewide basis.
- Elimination of duplicate case information through the use of one central database.
- Better crime trend analysis on a statewide basis.
- Increase project management, timekeeping and tracking capabilities including administrative non-enforcement projects.
- Increase ability to collect and collate statistics on Fraud Division activities.
- Increased database security through multilevel user access controls.
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The FIDB project was selected by the Center for Digital Government in conjunction with the *Government Technology* magazine for the award "Best Application Serving a Department or Agency's Business Needs" in November 2002.

Outreach

Public

UnderCover Newsletter - The UnderCover Newsletter, published semi-annually, informs the insurance industry, law enforcement personnel, and insurance consumers about the business of insurance fraud and the efforts of the Branch to mitigate insurance fraud in California.

Community Forums - CIB participates in community-sponsored events, which afford CIB staff an opportunity to better serve the public by hearing directly from the consumers regarding their insurance concerns, and providing them information they can use to protect themselves from insurance fraud.

Media/Public Service Announcements - Fraud Division supervisory personnel were invited panelists on local county cable talk shows hosted by the elected district attorneys to promote public awareness of the county's anti-insurance fraud program. Fraud Division personnel assisted a county in developing a workers' compensation video to distribute to business owners in California advising them of various fraudulent schemes and how to report suspected workers' compensation fraud. The Branch participates with local, state, and national broadcasting outlets to educate the public about the insurance fraud problem in California.

Industry

The Branch maintains ongoing liaison with the insurance industry by participation with the following groups:

- International Association of Special Investigation Units (IASIU)
- National Insurance Crime Bureau Regional Advisory Committee
- California Coalition on Workers' Compensation
- California Workers' Compensation Institute
- Northern California Fraud Investigators Association (NCFIA) - A Benicia Fraud Regional Office Supervising Investigator developed a program for the NCFIA training conference in April 2003.

- SIU training provided by Alameda County District Attorney Office and the Fraud Division in November 2003 attracted more than 300 participants in Berkeley.

Underground Economy Task Force
Assembly Bill 202 (Chapter 180, Statutes of 2001) amended Unemployment Insurance Code Section 329 to add CDI as a member of the Joint Enforcement Task Force on the Underground Economy, effective January 1, 2002. The task force has the general purpose of coordinating enforcement activities and sharing information for combating tax evasion problems and the failure to pay wages that are legally due. Emphasis is placed on enforcement of provisions relating to the payment of wages in cash with the intent to avoid the payment of taxes. Employers are required to have workers' compensation insurance or a certificate of self-insurance from DIR.

The task force includes representatives from the Employment Development Department, Department of Consumer Affairs, DIR, and the Office of Criminal Justice Planning. Statutory language also encourages participation from the Franchise Tax Board, Board of Equalization, and the Department of Justice. Current law invests the Task Force with the following authority:

- Forming joint enforcement teams.
- Establishing committees and rules of procedures.
- Soliciting cooperation from district attorneys and other agencies.
- Establishing procedures for soliciting referrals from the public.
- Improving information sharing among agencies.

New Cases Opened
During fiscal year 2002-2003, 827 new cases were assigned and a total of 199 arrests were reported with 257 cases filed with the district attorneys.

Employment Misrepresentation Task Force Report

Background

California law requires employers to have workers' compensation insurance that covers all of their employees for job-related injury and illness. Employers are also required by law to accurately report their payroll and to pay the appropriate payroll taxes. The loss in California to underground economy activity and fraud is estimated in the billions of dollars. These crimes place a burden on the State of California, on legitimate businesses, and on workers who lose benefits when employers operate in the underground economy. These types of investigations are particularly difficult due to the complexity of having to review and understand insurance documents, business records, tax information, and the needed coordination with other agencies.

In order to attack the problem of employers, who commit workers' compensation premium fraud, the CDI has become a member of the Joint Enforcement Strike Force on the

Underground Economy. The Fraud Division became part of this strike force through Assembly Bill No. 202 (Corbett), which amended Section 329 of the Unemployment Insurance Code and was approved and signed into law this year. This allows the Fraud Division to work with other state agencies in a coordinated effort to identify employers who, among other things, are committing workers' compensation premium fraud.

To meet the Department's responsibility for combating this area of insurance fraud, the Fraud Division has received authority for 12 positions: 7 General Auditors, 4 Investigators, and 1 Staff Services Analyst**.** Due to the hiring freeze, these positions have not been filled.

Protocols for Coordination with the WCIRB

The WCIRB can provide information that is useful during an investigation of Employment Misrepresentation. This information includes an employer's history of policies and insurance carriers, WCIRB audits, and other rating information. To facilitate the exchange of information between CDI Fraud Division and the WCIRB, the Fraud Division has established a protocol that all investigators are to follow. In brief, the staff from the Fraud Division must request information from the WCIRB through a letter that has been reviewed, approved and signed by the Chief Investigator of the Fraud Division's Regional Office. Any investigator requesting information from the WCIRB on behalf of another agency must follow the same procedure. The WCIRB has instructed their staff to assist the Fraud Division after a letter has been received. Recently, AB 1099 which will become effective on January 1, 2004 has included the Employment Development Department (EDD) as one of the agencies authorized to request and receive information regarding workers' compensation fraud investigations. It also permits insurance companies to notify EDD when they know, or reasonably believe they know the identity of a person or entity that has committed workers' compensation fraud.

Description of Employment Misrepresentation Program

The following is a list of the regional offices and a summary of their coordinated efforts to address premium fraud in their region:

Benicia Regional Office: This office has investigated 40 premium fraud cases for the fiscal year 2002-03. Four cases were closed during the same period. The office has good communications with the Employment Development Department in that region and has provided outreach to many unions such as the Northern California Regional Carpenters Council and Roofing.

Rancho Cucamonga Regional Office: This office has 56 premium fraud cases under investigation, an increase of 33 cases from fiscal year 2001-02. These cases involve active cooperation with Fraud Division, San Bernardino County District Attorney's Office, State Compensation Insurance Fund and the Employment Development Department. Recently, a massive search warrant has been conducted with more than 100 investigators for the case of Checkmate with an estimate of $20 million to $30 million premium theft.

Commerce Regional Office: This regional office has 13 premium fraud cases under investigation. Five cases were closed during fiscal year 2002-03. Commerce Office

continues to develop cooperative and/or joint investigations with allied law enforcement agencies, state regulatory agencies, and working relationships with specialty insurers.

San Jose Regional Office: This regional office has investigated 15 premium fraud cases in fiscal year 2002-03. Three cases were closed during the same period. Two of the cases are relatively high profile, both of which involve cooperation with the Employment Development Department.

Sacramento Office: The staff of this regional office has 22 premium fraud cases open as of July 1, 2003. A specific case, Gudgel-Yancey Roofing which involves over $1,000,000 in underreported payroll was concluded with the cooperation of the Employment Development Department and the State Compensation Insurance Fund.

Valencia Office: The staff of this regional office is working **16** premium fraud cases with state and local agencies in their area. One current case includes a company that has previously reported a payroll of $20,000 for two employees. Subsequent evidence seized indicates that the payroll was actually more than $2.1 million and involves over 100 employees. This case is a joint effort with the Employment Development Department and the Los Angeles District Attorney.

San Diego Office: The San Diego Regional Office has 42 cases under investigation in fiscal year 2002-03 with 5 cases that were closed. The office has assigned several investigators to work on premium fraud cases jointly with the San Diego County District Attorney's Office.

Orange Regional Office: has investigated 9 and closed 8 premium fraud cases.

Fresno Regional Office: is investigating 1 premium fraud case.

In summary, the status of the Employment Misrepresentation Program of the Fraud Division indicates 174 premium fraud cases are opened at the end of fiscal year 2002-03. These investigations are record intensive. Experience demonstrates that these investigations and prosecutions are highly detailed, and the prosecution is strongly defended. Program growth and impact measurement will be over a longer period of time; a complete measurement of the effect of this effort by any party is premature at this time. Nevertheless, the CDI Fraud Division will continue to build a comprehensive program to combat fraud in Employment Misrepresentation cases. In the process, the Fraud Division and other law enforcement and allied agencies, will continue their efforts to reduce the numbers of those who commit fraud by failing to pay full premiums for workers' compensation insurance in the State of California. The result of this effort is to make the work environment for California employers more equitable and to stimulate fair business competition throughout the state.

Uninsured Employer Fraud

Assembly Bill 749 (Statutes of 2002-Calderon) authorizes the Fraud Division and district attorneys to utilize the fraud assessment funding to attack crimes by employers of willful failure to obtain workers' compensation insurance. Present law makes that offense a

misdemeanor violation punishable by incarceration in the county jail and/or fines. For the period of January 1, 2003 to June 30, 2003, fifty eight (58) uninsured employer cases were opened and 7 arrests were reported.

District Attorneys

The Local Assistance Program has grown from initially 16 grant funded counties to the present 37 counties. Initially, a number of counties declined to participate because the level of funding was too low to establish a program. As the Fraud Assessment Commission recognized the importance of a meaningful enforcement effort, it raised the funding to $25 million in FY 1993-94. The funding continued at the same level for FY 1994-95 and 1995-96 in order to assure statewide coverage of the anti-fraud program. In FY 1996-97, the level of assessment remained at $25 million with the district attorneys receiving a funding increase from $12.5 to $14.4 million, due to an extra $1.9 million from criminal fines and restitution, which was deposited in the Workers' Compensation Fraud Account. In recognition of the rising caseload, the Fraud Assessment Commission voted to increase the level of assessment from $25 million to $28.5 million for FY 1997-98 and to continue the same level of assessment for FY 1998-99 with $16 million to District Attorneys and $12.5 million to the CDI Fraud Division. In FY 1999-2000, the District Attorneys portion was increased to $16,838,000 and the same level was assessed in FY 2000-2001. In fiscal years 2001-02 and 2002-03, $31.5 million was assessed with the district attorneys at $17,325,000 and the Fraud Division at $14,175,000.

The number of prosecuted cases for FY 2002-03 totaled 660 cases consisting of 739 suspects of which 293 were convicted. Many cases are still pending in court. The year-end report data included the number and type of investigations opened and carried from the previous fiscal year. Applicant fraud continues to be the area generating the greatest number of cases, 1,263 applicant fraud cases out of 1,739 cases. District attorneys reported 366 arrests for the same fiscal year and 116 search warrants were conducted. With the passage of SB 1053, Chapter 885, Statutes of 1995, which mandates reporting, investigation and prosecution of employment misrepresentation, the number of employment misrepresentation cases was 207 cases.

Type of Investigations	**FY 2002-2003 Cases Number / Percent**	**FY 2001-2002 Cases Number/ Percent**
Applicant	1,263 – 72.63%	1,293 –79.37 %
Premium	207 – 11.90%	159 - 9.76%
Fraud Rings	7 - 0.4%	1- 0.06 %
Capping	5 – 0.28%	6 - 0.37 %
Medical Provider	97 – 5.6%	98 - 6 %

Insider	6 – 0.34%	8 - .49 %
Other Uninsured	93 – 5.3% 61 – 3.5%	64 - 3.93 % NA
TOTAL	**1,739**	**1,629**

Fines and Restitution
In many instances, workers' compensation insurance fraud cases are most challenging to prosecute because of their magnitude and complexity. Extensive investigations and litigation are required for cases involving medical-legal mills and employment misrepresentation, particularly when the perpetrator is a businessman, doctor, or attorney who has accumulated vast wealth through his criminal activities. These clinics usually hire highly paid aggressive defense attorneys. This translates into voluminous motions, ceaseless litigation that can consume enormous amounts of investigative time and attorney time spent in court due to hearings on remote issues raised by the defense. With the adjudication of more workers' compensation fraud cases, the court ordered $12,473,590 in restitution; district attorneys reported $4,001,009 collected restitution. During FY 2002-2003, $228,645 of fines was ordered and $129,058 was collected.

Audit Reports
In FY 1993-94, Audit Guidelines were developed and distributed to every Local Assistance program. In September 1996, in accordance with the request of the Department of Finance, the Audit Guidelines were amended to more fully reflect the local assistance mandate. Of 34 funded counties in FY 2002-2003, to date, twenty six counties have submitted their audits to comply with the Audit Guidelines. The guidelines standardize the content and format of the audits, enabling the Fraud Division staff to communicate more effectively with county auditors and program staff about program activities and expenditures.

Joint Investigative Plan
The Joint Investigative Plan for Workers' Compensation fraud cases has been significantly revised in FY 1999-2000 and is required as a condition for funding. Clear timelines have been established to control the flow of cases from the initial referral through filing and sentencing. The Joint Investigative Plan for each county represents a sincere attempt to coordinate efforts on investigations earlier between the Fraud Division and local District Attorney. In general, to assure the coordination of efforts and to avoid any duplication of activities, the Fraud Division and district attorneys consult on intake matters that appear to warrant the opening of an investigation. When a decision is made to open an investigation, an investigator from the Fraud Division, District Attorney, or both is assigned. When the Fraud Division opens an investigation, the Division contacts the district attorney's intake deputy to have an attorney assigned. Regular meetings between the Division and district attorney's staff have expanded avenues of communication and created a greater understanding by all as to what is needed to investigate and prosecute workers' compensation fraud cases. In the majority of counties, monthly meetings are held between the assigned case investigator and prosecutor, as well as between the Chief Investigator and the District Attorney's staff in charge of the program.

Samples of Major Cases

1. Donna Hayes (Alameda County)

The defendant was charged with lying about a slip and fall case against her employer. Hayes claimed that she slipped and fell on her employer's property. It is alleged she was injured otherwise. Fireman's Fund Insurance paid almost $2.5 million on her slip and fall claim and there is the prospect for another $1.5 million or more on the workers' compensation claim. The case against Donna Hayes' daughter, Jacquetta Hayes, was dismissed after Jacquetta agreed to testify against her mother who threatened her to get her to lie. The Grand Jury indicted Donna Hayes in June 1999 and she was arraigned in July 1999. Three law firms represented Donna Hayes. Numerous motions to reduce bail, to squash subpoenas duces tecum, for return of seized property, special master, to recuse the prosecutor (Alice Sprague), are a few strategies submitted. Bank accounts were searched and new charges were filed against Enis Harrison (Donna's sister) and Kelly Lockhart. The new charges against Donna Hayes involved a fraudulent claim against Primerica Insurance Company relating to the same alleged injury, conspiracy to commit grand theft on her workers' compensation claim, money laundering, and concealment of stolen property with the fraudulently obtained money on her workers' compensation claim. The charges against Enis Harrison involve aiding and abetting workers' compensation fraud, grand theft, money laundering, concealing stolen property, forgery and conspiracy to commit forgery. Although many motions were filed, the court rejected all. Donna Hayes pled to every charge (35) that was filed by Alameda County District Attorney Office.

As the result of her plea, the following demands were made:

1. Donna Hayes signed the deed of her home over to Fireman's Fund, the victim insurance company.
2. Donna Hayes signed over the annuity to Fireman's Fund,
3. Donna Hayes dismissed her workers' compensation claim with the Port of Oakland. Her last demand to settle was $1,500,000.
4. Donna Hayes dismissed her civil action against the Port of Oakland, Lisa Bartlow, the claim manager and Fireman's Fund.

Donna Hayes was sentenced to five years' probation and to serve one year in the county jail. She was ordered to pay restitution in excess of $2,000,000. In fiscal year 2001-02, Fireman's Fund received almost $900,000 from the resolution of the criminal cases. This case alone occupied a full time prosecutor and a district attorney investigator for more than five years.

To date, Donna Hayes has made no effort to obtain meaningful employment and therefore, Alameda County District Attorney is seeking to revoke her probation for failure to take appropriate action to pay restitution. The county plans to seek the extension of Donna Hayes's probation to 14 years.

Donna Hayes's sister, Enis Harrison will go to trial and the date was set for August 11, 2003.

2. Highland Framers (Alameda County)

A coordinated investigation conducted by the California Department of Insurance, Employment Development Department, California Franchise Tax Board, and the Alameda County District Attorney's Office has resulted in multiple felony counts of workers' compensation insurance fraud and employment tax evasion charges filed against four individuals. Investigators were assisted by numerous entities, including the Arizona Department of Insurance, the State Compensation Insurance Fund and Golden Eagle Insurance Company.

Jay Neal Wright, age 48, and his son Jay Neal Wright II, age 27, both residential framing contractors of Phoenix, Arizona; Don Jay Wright, age 80, of Mesa, Arizona; and Attorney Timothy Miller, age 43 of Riverside, California were charged with multiple felony counts of workers' compensation insurance fraud and employment tax evasion. Arrest warrants were issued for all four suspects. Attorney Timothy Miller surrendered to authorities immediately following warrants issuance.

Investigators found that Jay Neal Wright and his son headed a large residential framing company, Highland Framers of Northern California, Inc., with a multi-million dollar payroll, that did business primarily in and around Alameda and Contra Costa Counties throughout much of the 1990s. In late 1993, the Wrights allegedly represented to insurers and California employment tax authorities that they had divested themselves of their carpentry labor force and were instead using outside subcontractors for their labor. However, an examination of the alleged subcontractors used after 1993 revealed that at least two were merely shell corporations operated under direct control of Highland Framers. It is believed that the shell corporations, allegedly created with the assistance of attorney Timothy Miller, were made to appear unrelated from Highland Framers, both in terms of ownership and control, in order to avoid paying the appropriate workers' compensation insurance premiums and California employment taxes.

Search warrants were served in California, Arizona, and Nevada. Locations included business addresses, an attorney’s office, residences, two insurance brokers’ offices, banks, and payroll companies. The case resulted in the seizure of 150 boxes of evidence. The victim insurance carriers included SCIF, Golden Eagle, Farmers, Superior National, Frontier Pacific, and Credit General and involving approximately 12 workers’ compensation insurance policies. Investigators stated that the fraud cost approximately $3 million in losses to insurers and approximately $6 million in losses to the state of California.

The attorney in this case, Timothy Miller pled guilty and surrendered his license. The prosecution of the other defendants, Jay Wright, Jay Wright II, and Don Jay Wright is still in the preliminary stages and the next court date was set for September 10, 2002. After many months of delay by the defense, mainly due to one attorney being in a death penalty trial for nine months, Alameda County District Attorney Office decided to seek a grand jury indictment. That indictment was returned against all defendants on June 16, 2003 and the next court date was June 30, 2003, for the arraignment of the defendants on the indictment.

3. William Ghazey & Frank Rojas DBA Fastek & CP Services (Alameda County)

The case was initially referred by State Compensation Insurance Fund (SCIF) to the Los Angeles County District Attorney but was rejected due to jurisdictional ground. The case was then referred to Alameda County District Attorney's Office. The office enlisted the assistance of the CDI Fraud Division, EDD, and the Franchise Tax Board along with SCIF, Golden Eagle and Superior to set up a multi agency investigation. This case involved a company by the name of Fastek that set up a shell company called CP Services to avoid paying a higher premium on their workers' compensation insurance. The defendants, Ghazey and Rojas, are senior executives of Fastek.

In February 1999, a search warrant was served at five different locations in California, two of which were in Orange County, two in Alameda and one in Contra Costa County. Over two hundred boxes of evidence were taken including computers and computer records. Review of the evidence revealed that the defendants were suspected of an additional type of premium fraud, by misclassifying their employees to achieve lower premiums. The estimated loss in this case is $700,000.

Numerous motions by defendants to suppress evidence and all rulings were in favor of the People. In September 28, 2001, a new attorney entered the case to represent Mr. Rojas. On February 21, 2002 the parties met with the master trial calendar judge to discuss settlement of the case which the defendants rejected any disposition other than dismissal of the case. The trial dated was set for November 12, 2002. Before that date, the third of Rojas'succession of attorneys filed a motion to withdraw from the case. The motion was granted and the trial was rescheduled to January, 2003 to allow a replacement attorney time to prepare and a new trial date was set for April 1st, 2003. Both defense counsels filed for continuances and cited a desire for the defendants to be tried separately. The new trial date was set for September 15, 2003.

4. Roofing Contractor Held in Death of Worker (San Francisco County)

Christie Binh Chung, a well known local roofing contractor, was arrested and was charged in the death of an employee, Miguel Moncada Ortiz. Two of Chung's employees, Dat Kham Ha, 45, and Bao Thien Luong, 53, were arrested by investigators from the San Francisco District Attorney's Insurance Fraud and Special Prosecutions Units and the Fraud Division of the California Department of Insurance on arrest warrants. Bao Thien Luong, 53 was arrested on July 23, 2002. Bail was at $1 million for Chung and $20,000 each for Ha and Luong. All three are charged with felony involuntary manslaughter, as well as felony violations of the State labor code alleging safety violations, which caused the death of a worker.

Chung is the owner of 101 Roofing Inc. located in San Francisco. Both Chung and 101 Roofing Inc. were charged with additional felony violations of workers' compensation insurance premium fraud, alleging fraudulent underpayments to the State Compensation Insurance Fund, unemployment insurance fraud, alleging the failure to adequately report and pay moneys due to the California Employment Development Department, and California

income tax fraud, alleging failure to adequately report income and pay taxes due to the California Franchise Tax Board.

Chung was charged with filing a false tax return for his corporation's 1994 through 1997 tax years and failing to file a tax return for the 1998 tax year. According to investigators, Chung underreported his corporation's gross sales by $4.3 million during this these years and underreported the income on his corporate tax returns for 1994 through 1997 and did not file a 1998 return. The tax due on the unreported income is over $1 million. Chung, in an effort to avoid reporting this income, cashed more than half the checks received by his business at a check-cashing establishment. Investigators also state that Chung paid his employees cash and did not report his employees to the Employment Development Department (EDD) in an effort to avoid payroll taxes.

Superior Court Judge Gerald Reagan imposed a three-year state prison sentence. Chung was ordered to make restitution payments to the California Franchise Tax Board in the amount of $1,539,757 to the California Employment Development Department in the amount of $880,072; and to the California State Compensation Insurance Fund in the amount of $499,245.

The co defendants Dat Kham Ha, 46, and Bao Thien Luong, 55, both pled guilty to labor code violations (6425) and were sentenced to 3 years probation and 30 days in county jail.

5. James Stakely, M.D. (San Diego County)

A San Diego physician indicted on 23 counts of workers' compensation-related insurance fraud and perjury has been arrested after a joint undercover investigation by the California Department of Insurance (CDI) Fraud Division, the San Diego County District Attorney's Office, and the Office of the Inspector General, U.S. Postal Service.
James Louis Stakely, 65, was taken into custody Wednesday and a search warrant was executed at his business, Industrial Physician Medical Group. Investigators found a large amount of cash at the site. Bail was set at $100,000. Undercover operatives posing as patients with work-related injuries were sent to Stakely's office beginning in 1999. According to investigators, Stakely never conducted a physical examination of the first operative, but placed him in a non-work status for 18 months. He also recommended that the operative receive an MRI and undergo other procedures. A second operative was sent to Stakely in 2001 complaining of an alleged back injury suffered on the job. Investigators said that Stakely never conducted a physical examination, but ordered an MRI. On both operatives Stakely ordered dye injections to allegedly determine if there were spinal injuries, advising them that they would be eligible for a permanent total disability retirement and compensation package.

If convicted of the charges, Stakely could face up to 20 years in prison and/or a $50,000 fine.

6. Edgar Esparza and Franco Gamboa, DCs. (Orange County)

Two Southern California chiropractors and a medical clinic owner were arrested today on charges of workers' compensation fraud following two investigations by the California Department of Insurance (CDI) Fraud Division.

Edgar Esparza, 28, of Downey, and Franco Gamboa, 46, of Diamond Bar, are charged with 12 felony counts of insurance fraud and workers' compensation fraud. Investigators charge that they illegally paid undercover officers to bring them potential patients, and then submitted bills for treating non-existent injuries. They were arrested at their homes.

Hilda Fernandez, 61, the owner of South Gate Medical Clinic, was arrested at her home in La Canada. She is charged with four felony counts of insurance fraud and workers' compensation fraud. Investigators said she paid undercover officers to refer patients to her clinic, and then submitted false medical billings for treatment that was never performed.

If convicted on all charges, the chiropractors could face up to 10 years and four months in prison and a fine of $350,000. Fernandez, if convicted, could receive a sentence of seven years and eight months in prison, as well as a fine of $160,000. Bail was set at $25,000 for each of the three suspects.

In connection with the case, search warrants were executed at homes and offices in South Gate, Downey, Santa Ana, La Canada and Diamond Bar. Grand Jury indictments were issued for the arrests. The CDI Fraud Division received assistance in the execution of the search and arrest warrants from the Orange County District Attorney's Office – Economic Crimes Unit, members of the Orange County Auto Theft Task Force (OCATT) and local agencies within each jurisdiction where the warrants were served.

7. Checkmate (San Bernardino County)

More than 100 law enforcement officers and investigators served search warrants at offices of CheckMate Staffing Inc. throughout Southern California.

The investigation of CheckMate is part of a stepped-up effort by the Department of Insurance to fight abuses in the state's troubled workers' compensation system. The search warrants were authorized by a Superior Court judge in San Bernardino County.

This case is one of the largest premium fraud cases the Fraud Division has ever investigated. It is anticipated that the total premium theft is between $20-$30 million dollars. Checkmate is a temporary employment agency, one of the larger ones in the state. Investigation has revealed that Checkmate misclassified its employees to pay lower premiums. Search warrants were served in November at over 25 locations throughout the state with approximately 1300 boxes of evidence seized. San Bernardino County District Attorney is prosecuting the case

8. JVLM Construction, Gauthier Construction & C&H Framing (San Diego County)

Nine people associated with three construction companies were indicted on charges of workers' compensation insurance fraud and tax evasion totaling $1 million.

Seven of the defendants, associated with JVLM Construction in Palm Spring and Gauthier Construction in Carlsbad, allegedly paid a middleman their employee payroll plus a 20%

commission. The middleman paid the employees in cash and kept the commission as his payment. The two companies are charged with failing to report the cash wage payment to their workers' compensation insurance carrier and failing to collect and pay the required payroll taxes from the cash wages to EDD.

The remaining two defendants, associated with C&H Framing in Escondido, are charged with committing state income tax fraud by failing to report all their income to the Franchise Tax Board.

Each defendant faces a maximum of five years in prison if convicted.

9. Parviz Berjis, M.D. & Sam Salehi, D.C. (Los Angeles County)

A doctor, a chiropractor, a therapist and a former Los Angeles County employee were charged with organizing a large workers' compensation fraud scheme that has netted them more than $2 million since 1999.

Dr. Parvis Berjis, 69 pleaded not guilty and was ordered held in lieu of $500,000 bail. His medical license also was suspended. Sam Salehi, D.C. , 36 also entered not guilty pleas and two other alleged conspirators, Leroy Jaramillo, 55 and therapist Bijan Rahmani, 51 also involved in the scheme.

The case stems from a workers' compensation claim filed by Jaramillo as a result of an alleged injury he suffered in the 1980s while working as a welder at County-USC Medical Center. Los Angeles District Attorney Office allege in the 16-count complaint that Jaramillo submitted false mileage bills for visits to medical professionals he had never made and that in turn they billed for those non-visits on numerous occasions since 1999.

10. Noah Roofing (San Francisco County)

Investigators from the California Department of Insurance (CDI) Fraud Division and the Employment Development Department (EDD) arrested a San Francisco roofing contractor on three felony counts of workers' compensation premium fraud and nine felony counts of payroll tax evasion. Young Il Kim, 48, of Fremont, was arrested today and booked into the San Francisco County Jail. Bail was set at $100,000. If convicted, Kim faces up to 13 years in prison, $250,000 in fines and $113,000 in restitution.

The investigation revealed that Kim, owner of Noah Roofing, obtained a workers' compensation insurance policy through the State Compensation Insurance Fund (SCIF) in June 1998. However, it is alleged that from April 1, 1998 through June 2000, Kim paid cash to employees to avoid paying the proper premium to SCIF and underreported his total payroll to EDD. The investigation revealed a total of $75,649 in lost premium to SCIF; a tax audit determined that wages paid to employees were underreported by $175,215. The San Francisco District Attorney's Office is prosecuting the case.

11. Barthells Construction and Roofing (Contra Costa County)

More recently, on September 20, 2001, CDI investigators, with the assistance of the Richmond Police Department, served a search warrant at the residence of Dave Barthell in Richmond, California. Mr. Barthell was arrested at his residence on various charges, including submitting false information to the State Compensation Insurance Fund causing his workers' compensation insurance premiums to be lower, failing to comply with the report and tax withholding requirements, and perjury and signing and filing documents under penalty of perjury. Mr. Barthell and his wife Vicki, owners of Barthell Construction and Roofing, employed a number of people to perform roofing work between January 1995 and January 2000. The Barthells allegedly avoided paying the correct workers' compensation insurance premiums by reporting all payrolls under the clerical and sales categories instead of under the roofing and/or construction category. State Compensation Insurance Fund staff calculated the Barthells should have paid approximately $231,000 more in premium for the coverage of the employees who were doing roofing work.

In May 2003, David Sr. and Vicki Barthell were convicted in Contra Costa County Superior Court of five counts of felony workers' compensation insurance fraud. They were sentenced to five years probation and ordered to pay $187,000 in restitution to State Fund.

Summary

As the Workers' Compensation Insurance Fraud Program moves into FY 2003-04, some success has been realized in turning the corner on workers' compensation insurance fraud.

The current culture of California's worker's compensation system is one where abuse and fraud are widespread and serve as a cost driver in the system. This culture must change. The high premiums, low benefits, and overall inequity of the current workers' compensation system contribute to an environment that is highly vulnerable to fraud. Workers' compensation fraud ranges from abusive and fraudulent provider billing practices (up-coding, unbundling, prescription billing, durable equipment, and services not rendered) and medical-legal mills to applicant and insider fraud. Numerous factors exacerbate and perpetuate workers' compensation fraud, including personal and business economic hardship, public acceptance of insurance fraud, and inadequate resources (manpower and funding) to investigate insurance fraud cases. Some insurance companies have also been derelict in their responsibility to fight fraud. The lack of uniform methodology and standards for assessing and reporting suspected fraud is a contributing factor.

The California Department of Insurance (CDI) is restructuring, re-energizing, prioritizing and coordinating its fraud and investigation units and seeking to improve its working relationship with district attorneys and other state, federal, and local law enforcement agencies with an emphasis on information sharing. As part of these anti-fraud efforts, CDI supports increased criminal penalties for false or fraudulent statements and activities in connection with workers' compensation claims. CDI is also developing new regulations to help insurance carriers step up their anti-fraud efforts and become more effective in identifying, investigating, and reporting workers' compensation fraud. The Department is developing a work plan to increase the number of audits performed by the Fraud Division SIU (Special Investigations Unit) Compliance Unit and continuing with an aggressive outreach plan to educate the public on anti-fraud efforts and how to identify and report fraud. Finally, CDI is strengthening its working relationship with the Workers'

Compensation Insurance Rating Bureau (WCIRB) to support the Department's anti-fraud efforts. This includes the WCIRB developing an effective special investigations unit, obtaining the same immunity from liability for reporting fraud that insurance companies have and supplying CDI with timely access to their data.